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No. 85-1763

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM 1985

FLORENCE NIGHTINGALE NURSING HOME,

Petitioner,

vs.

CESAR PERALES, individually and as Commissioner of the New York State Department of Social Services, and GEORGE GROSS, individually and as Administrator/Commissioner of the New York City Human Resources Administration,

Respondents.

CITY RESPONDENT'S BRIEF IN OPPOSITION TO A PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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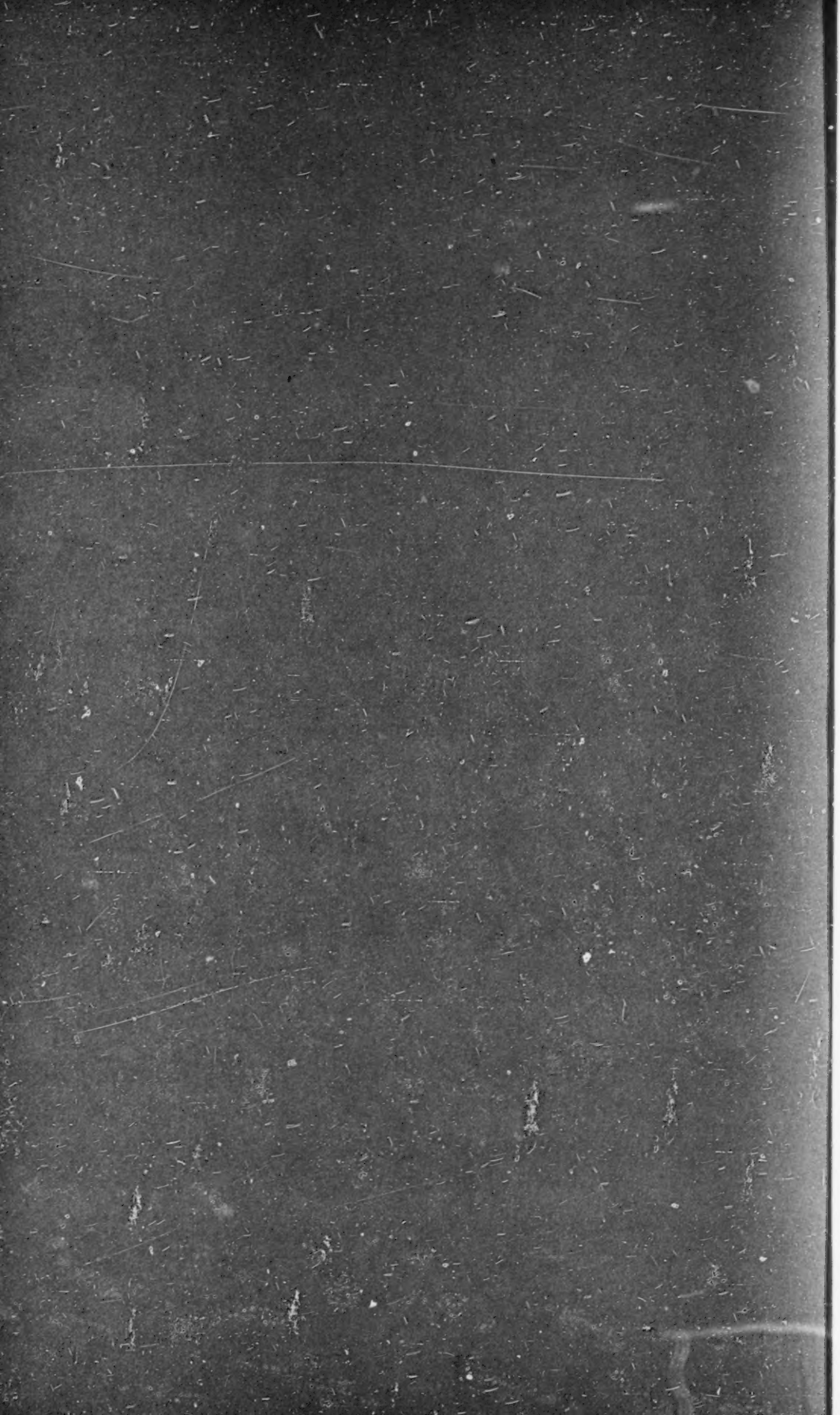

QUESTION PRESENTED

Whether public funds can be used to reimburse petitioner nursing home for money owed by medicaid patients for the cost of care which is the patient's responsibility, where such reimbursement is prohibited by federal statute and regulations.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iii
STATEMENT OF THE CASE	1
DECISIONS BELOW	8
REASONS FOR DENYING THE WRIT	
PETITIONER HAS FAILED TO SET FORTH SPECIAL OR IMPORTANT REASONS FOR GRANTING A WRIT OF CERTIORARI IN THIS MATTER	13
CONCLUSION	22

TABLE OF AUTHORITIES

Cases:	Page
Alabama Hospital Association v. Beasley, 702 F2d 955 (11th Cir., 1983)	20
Connecticut Department of Income Maintenance v. Heckler, ___ US ___, 105 S Ct 2210 (1985).....	14
DeJesus v. Perales, 770 F2d 316 (2d Cir., 1985)	14
Florence Nightingale Nursing Home v. Blum, 570 F Supp 285 (S.D.N.Y. 1983).....	5, 9
Florence Nightingale Nursing Home v. Perales, 782 F2d 26 (2d Cir., 1986)	11
Friedman v. Berger, 547 F2d 724 (2d Cir., 1976), cert. denied, 430 US 984 (1977).....	3
James v. Harris, 499 F Supp 594 (M.D. Ala. 1980), aff'd on opinion below, 650 F2d 814 (5th Cir., 1981)	16
Seneca Nursing Home v. Secretary of Social and Rehabilitation Services of Kansas, 604 F2d 1309 (10th Cir., 1979)	6, 9, 10, 11, 12, 13

Statutes:

42 USC §1396	2
42 USC §1396a(a)(13)(A).....	6
42 USC §1396a(a)(13)(E).....	6, 9, 15, 19, 20

Regulations:

42 CFR §405.420.....	18
42 CFR §435.725.....	16
42 CFR §435.733.....	16
42 CFR §435.832.....	16
42 CFR §435.1002.....	16
42 CFR §436.832	16
42 CFR §447.15.....	6, 9, 11, 12
42 CFR §477.53	18, 19

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STATEMENT OF THE CASE

The medicaid program was enacted by Congress in 1965 under Title XIX of the Social Security Act to provide federal financial assistance to participating states for

the cost of providing health care to needy individuals (JA200, JA210).[1] See 42 USC §1396 et seq. Under the program a single state agency in each participating state is responsible for operating a statewide medical assistance plan (JA140, JA148). State respondent, Cesar Perales, is Commissioner of the New York State Department of Social Service ("DSS") which implements and administers the New York State medicaid program (JA148, JA201). City respondent, George Gross, is the Commissioner of the New York City Human Resources Administration ("HRA"), the local social service agency, which shares the cost of

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[1]Unless otherwise indicated, references within parentheses preceded by "App." are to the Appendix to the Petition for Certiorari and those references preceded by "JA" are to the Joint Appendix filed in the Circuit Court.

long-term care with the federal and state governments and the patient (JA27).[2]

Medicaid patients who reside in long-term care institutions must contribute most of their income to help pay for the cost of their care, retaining only an allowance for their "personal needs" and such income as is deemed necessary to meet the maintenance needs of their former family household (JA201, JA202, JA210, JA211). See Friedman v. Berger, 547 F2d 724 (2d Cir., 1976), cert. denied, 430 US 984 (1977). The amount that the medicaid recipient is required to pay to the nursing home as his contribution

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[2]Prior to December 1, 1978, DSS delegated to HRA the task of receiving and evaluating claims for reimbursement submitted by New York City providers, for services rendered to New York City residents (JA201, JA210). Since 1978, it is the State that receives, evaluates and pays such claims, and then seeks the local and federal contributory shares (JA201, JA210).

to the cost of care is known in New York State as the patient's Net Available Monthly Income ("NAMI") (JA202, JA211).

Petitioner, Florence Nightingale Nursing Home, furnishes long-term care to medicaid recipients (JA201, JA274, JA275). In October 1980, petitioner commenced this action in the United States District Court for the Southern District of New York, seeking, inter alia, reimbursement from State and City respondents for patients' uncollected contributions to the cost of care (JA9-11).[3]

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[3]From 1973 to 1978, HRA reimbursed nursing homes, such as Florence Nightingale, for 98% of a recipient's NAMI, if the institution certified that it had been unable to collect the NAMI directly from the recipient (JA211). In a 1980 audit, the United States Department of Health and Human Services stated that, as a result of this policy, the City and State had overclaimed the sum of $1.1 million in federal medicaid funds (JA153, JA211, JA253). Subsequent thereto, the State recovered $1,751,162 from the City, alleging that, as a
(Footnote Continued)

On November 25, 1980, City respondent answered and State respondent moved to dismiss the complaint on the grounds, inter alia, that petitioner failed to state a claim (JA19, JA32).

In Florence Nightingale Nursing Home v. Blum, 570 F Supp 285 (S.D.N.Y. 1983), the District Court denied State respondent's motion to dismiss, holding that the state medicaid agency,not the nursing home, was required to bear the loss for the uncollected amount of a patient's contribution to the cost

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(Footnote Continued)
result of the City's policy, the City had improperly appropriated this sum from the state and federal medicaid funds (JA211). HRA now believes that medicaid funds cannot be used to reimburse NAMI, even when the institution cannot collect the NAMI directly from the recipient (JA211, JA212). The City is, nonetheless, objecting in a state court proceeding to the State's action in recovering the $1,751,162, in large part because it alleges that DSS knew of and approved of the HRA's prior policy. City of New York v. State of New York, The New York Court of Claims, Claim No. 71082.

of care. (JA30, JA33). In reaching this conclusion, the District Court relied on a provision in the medicaid statute, 42 USC §1396a(a)(13)(E), which, at that time, required the state to pay for long-term care services provided under the plan on a "reasonable cost" basis[4] and a federal regulation, 42 CFR §447.15, which requires providers to accept, as payment in full, the amount paid by medicaid (JA30, JA33). In addition, the Court analogized to the decision in Seneca Nursing Home v. Secretary of Social and Rehabilitation Services of Kansas, 604 F2d 1309 (10th Cir.

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[4]The statute was amended in 1980 to require state medicaid plans to provide payment at a rate which the state finds is "...reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 USC §1396a(a)(13)(A). This provision does not, however, require the state medicaid agency to reimburse the institution 100% of that rate.

1979) where the Court of Appeals held that under Kansas state law the state of Kansas should pay recipients' uncollected private liabilities (JA30, JA33).

On November 16, 1984, petitioner noticed a motion for partial summary judgment seeking declaratory and injunctive relief in addition to an award of $72,412.01 for payments allegedly owed by patients. Petitioner claimed that respondents were obligated to reimburse the nursing home for a patient's unpaid liability (JA101).

On December 17, 1984, City respondent cross-moved for partial summary judgment on the ground, inter alia, that pursuant to federal regulations, medicaid funds cannot be used to reimburse nursing homes for recipients' uncollected payments (JA199, JA208). Relying on the same federal regulations State respondent also

cross-moved for partial summary judgment (JA138).[5]

DECISIONS BELOW

The District Court issued an endorsed memorandum decision partially granting petitioner's motion for summary judgment and enjoining respondents from refusing to reimburse petitioner for Medicaid recipients' unpaid contributions (JA278). Petitioner's motion was denied to the extent that it sought an award of $72,412.01 for uncollected payments, and a trial was ordered on the issue of damages (JA278).

In granting petitioner's motion, the District Court recognized that its decision was contrary to federal regulations which require state medical assistance programs to

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[5]In addition, State respondent sought leave to implead the United States Department of Health and Human Services ("HHS").

reduce their payments to long-term care institutions by a sum equal to the Medicaid patient's contribution to the cost of care (JA278). Rejecting these unambiguous federal regulations, the District Court however, based its decision on the reasoning set forth in the Court's prior opinion denying State respondent's motion to dismiss, Florence Nightingale Nursing Home v. Blum, 570 F Supp 285 (S.D.N.Y. 1983) (JA30, JA278). In denying the motion to dismiss the Court had relied on three factors: (1) a section of the medicaid statute, 42 USC 1396a(a)(13)(E), which, at that time, had provided for reimbursement based on a reasonable cost basis; (2) a federal regulation, 42 CFR §447.15, which required providers to accept as payment in full, the amount paid by the state medicaid agency; and (3) the Tenth Circuit decision in Seneca Nursing Home v.

Secretary of Social and Rehabilitation Services of Kansas (JA30).

City and State respondents appealed the District Court's order which was in clear conflict with federal regulations (JA292, JA298).[6] The United States Department of Health and Human Services ("HHS") submitted an amicus curiae brief in support of reversal.[7]

The United States Court of Appeals for the Second Circuit reversed the judgment of the District Court and vacated the injunction, holding that (App. A-6):

> Both the statute and the regulations make clear that the financial responsibility for patient

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[6]State respondent also appealed from the District Court's denial of the State's motion for permission to implead HHS (JA298-299). On appeal, the Court of Appeals declined to reach the third-party issue (App. A-2).

[7]We are submitting with this brief in opposition one copy of HHS's brief to the Court of Appeals.

> NAMI is not borne by the Medicaid program. The burden of uncollectible NAMI does not fall on the city, state or federal government but rather on the institutional provider.

Florence Nightingale Nursing Home v. Perales, 782 F2d 26, 29 (2d Cir., 1986).

In reaching this conclusion, the Court of Appeals accorded substantial deference to HHS's view that 42 USC §1396a(a)(13)(E) required only reasonable cost based payments by the state for the cost of services covered by medicaid and that a patient's NAMI is not a covered service (App. A-4, App. A-5). The Court of Appeals noted that this interpretation of the statute was plainly supported by regulations prohibiting such reimbursement (App. A-5).

Rejecting the District Court's reasoning, the Court of Appeals concluded that neither 42 CFR §447.15 nor Seneca Nursing Home v. Secretary of Social and Rehabilitation Services of Kansas, supra, 604

F2d 1309, supported a determination that the providers were entitled to reimbursement for unpaid NAMI (App. A-5, App. A-6). The Court of Appeals noted that 42 CFR §447.15 simply prevents providers from seeking contributions from patients in excess of the limits set by medicaid, and does not transfer responsibility for payment of the patient's liability to the Medicaid agency (App. A-5). Moreover, the Court of Appeals concluded that the decision in Seneca Nursing Home was inapplicable. In Seneca Nursing Home the Court of Appeals for the Tenth Circuit held that the state medicaid agency was required under a Kansas statute to reimburse the medical provider for patients' uncollected contributions (App. A-5). The Second Circuit stressed that in this case there is no such provision in the federal statute nor is there a New York statute analagous to the Kansas statute (App. A-6).

REASONS FOR DENYING THE WRIT

PETITIONER HAS FAILED TO SET FORTH SPECIAL OR IMPORTANT REASONS FOR GRANTING A WRIT OF CERTIORARI IN THIS MATTER.

Petitioner seeks this Court's review on the grounds, inter alia, that the Court of Appeals' ruling that the city, state and federal government are not required to reimburse petitioner for uncollectible NAMI is in conflict with the decision of the Court of Appeals for the Tenth Circuit in Seneca Nursing Home v. Secretary of Social and Rehabilitation Services, supra. However, as petitioner acknowledges the Seneca decision allowing reimbursement to a nursing home for patients' contributions to the cost of care was based on a Kansas statute, and not federal or New York law. Therefore, no actual conflict between the circuits has been presented to this Court. Nor has petitioner

presented any other reason warranting this Court's review.

The Court of Appeals properly accorded substantial deference to HHS's view that uncollected NAMI is not reimbursable (App. A-5). See Connecticut Department of Income Maintenance v. Heckler, ___ US ___, 105 S Ct 2210, 2215 (1985); DeJesus v. Perales, 770 F2d 316, 327 (2d Cir., 1985). This view was set forth in an amicus curiae brief submitted by HHS to the United States Court of Appeals in support of reversal of the District Court's order (App. A-5). Petitioner has failed to set forth any reasons why this Court should review the judgment of expert administrators on an issue which raises complex questions of federal statutory interpretation.

In its amicus curiae brief HHS explained that pursuant to detailed reimbursement procedures, the states reimburse the

provider or nursing home under prescribed reimbursement rates for medicaid care costs, for services provided under the plan. These medicaid care costs, according to HHS, do not include that portion of a patient's care for which the patient is financially responsible (App. A-4). As interpreted by HHS, section 1396a(a)(13)(E) does not provide for 100% reimbursement of the reasonable cost of services where such services are not covered by Medicaid or "provided under the plan" because of a patient's available income (App. A-4).[8]

The Court of Appeals correctly found that HHS's interpretation of the statute was further supported by federal regulations drafted by HHS which prohibit

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[8]Paragraph E as enacted provided for reimbursement for services rendered under the plan on a reasonable cost related basis.

reimbursement to nursing homes of a patient's contribution to the cost of care (App. A-5).[9] 42 CFR §§435.725; 435.733; 435.832; 435.1002; 436.832. The regulations unambiguously provide that:

> The agency must reduce its payments to an institution for services provided to an individual..., by the amount that remains after deducting the amounts specified in paragraph (c) of this section [referring to an individual's personal needs allowance] from the individual's income.

42 CFR §§432.725 and 435.832 (emphasis added). See also James v. Harris, 499 F Supp 594 (M.D. Ala. 1980), aff'd on opinion below, 650 F2d 814 (5th Cir., 1981). As HHS stated in its brief these federal regulations make clear that states may not pay institutions the patient's NAMI.

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[9] 42 CFR §§435.725 and 435.1002 were promulgated in 1978, two years prior to the commencement of this action.

Petitioner claims without any citation of supporting legislation or legislative history that these regulations, which were promulgated by the agency with expertise in the field, are in conflict with the language and purpose of the medicaid statute. In contrast, the New York State Health Facilities Association, Inc. ("NYSHFA"), the Connecticut Association of Health Care Facilities Inc. ("CAHCF") and the American Health Care Association ("AHCA"), which have submitted an amici curiae brief in support of the petition for a writ of certiorari, note these regulations in a footnote and claim that they are "self-serving". The amici argue that the Court of Appeals' conclusion is incorrect because the Court allegedly confused the concepts of reimbursement, eligibility and costs in deciding this case. There is no merit to any of these contentions. The Court

of Appeals never even considered eligibility standards and it is the amici curiae who attempt to intertwine these distinct concepts.

In addition, petitioner now argues for the first time that a patient's contribution to the cost of care is reimbursable under medicare and that therefore such reimbursement should be permitted under medicaid. 42 CFR §405.420, the medicare regulation cited by petitioner for this proposition, limits reimbursement to bad debts attributable to deductibles and coinsurance amounts for covered services. It does not provide that NAMI is reimbursable under medicare.

NAMI is not a deductible or coinsurance amount. A medicaid regulation, 42 CFR 447.53, specifically excludes NAMI payments from the category of cost sharing under medicaid which includes deductibles and coinsurance. Under this regulation, the

medicaid plan may impose a nominal deductible, coinsurance, copayment or similar cost-sharing charge on the medicaid recipient. However excluded from such cost-sharing charges are institutionalized patients who are required to pay NAMI. 42 CFR 447.53 provides:

> Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution if the individual is required (pursuant to §§435.733, 435.832, or 436.832), as a condition of receiving services in the institution, to spend all, but a minimal amount of his income required for personal needs, for medical care costs are excluded from cost sharing.

Moreover, even if a patient's NAMI were reimbursable under the medicare statute and regulations, those provisions are not controlling. Section 1396a(a)(13)(E), originally gave states an opportunity, but did not require them, to reimburse medicaid providers in the same manner as medicare providers. Moreover, in 1980, section

1396a(a)(13)(E) was amended by §962 of the Omnibus Reconciliation Act to require states to provide payment through reasonable and adequate rates. "In revising the statute Congress sought to move away from the inflationary medicare reimbursment methodology.... Congress intended the efficient cost standard to reduce, not increase, the permissible level of reimbursement below that available under Medicare principles." Alabama Hospital Association v. Beasley, 702 F2d 955, 959, 960 (11th Cir., 1983).

Finally, there is no factual support in the record for petitioner's claim that nursing homes will incur severe monetary losses and withdraw from the medicaid program as a result of the Court of Appeals' decision in this case. Indeed, the record contradicts such an assertion. Uncollected NAMI has not been reimbursed in New York since 1978 and

there is nothing in the record to show that severe losses leading to withdrawals have occurred during the past eight years. See discussion, supra, at 4-5, n. 3.

Petitioner claims that it has not been reimbursed for uncollected NAMI since 1976 (JA 108). While petitioner contends that "...the amount at stake in this controversy is substantial", it does not assert that the $72,412 it claims in damages has forced it to withdraw from the program. Vague, speculative arguments about the effects of the Court of Appeals decision do not provide any special or important reason for granting a writ of certiorari. The petition should be denied.

CONCLUSION

THE PETITION FOR A WRIT OF CERTIORARI SHOULD BE DENIED.

July 8, 1986.

Respectfully submitted,

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